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Knock, and it will be opened to you? An evaluation of meridian-tapping in obsessive-compulsive disorder (OCD)

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ABSTRACT

Meridian-tapping (MT) is a body-oriented therapeutic technique which among other psychological problems targets anxiety disorders. Despite bold claims by some of its advocates that it brings lasting success in the vast majority of patients with anxiety disorders, solid empirical evidence for its effectiveness is scarce and its theoretical foundations are refuted by many scientists. The present study tested the effectiveness of a published MT self-help approach for obsessive-compulsive disorder (OCD). Following a baseline assessment over the internet including standard outcome measures for OCD (Y-BOCS, OCI-R) and depression (BDI-SF), 70 participants with OCD were randomly allocated to MT or to progressive muscle relaxation (PMR). Four weeks after the dispatch of the self-help manuals (including video demonstrations of the technique), participants were requested to take part in a post assessment. Whereas subjects found MT more helpful than PMR in retrospect (39% versus 19%) and would continue to use it in the future (72% versus 48%) there was no evidence for a stronger decline of OCD symptoms under MT on any of the psychometric measures. Moreover, Y-BOCS scores did not significantly change across time for both interventions. The present study does not support bold claims about the effectiveness of MT as a stand-alone technique. Cognitive-behavioral therapy remains the treatment of choice for OCD. While self-help MT may enhance the well-being of a subgroup of participants, its potential for OCD appears to be small. Exaggerated success claims on the effectiveness of MT in conjunction with degrading appraisals of conventional psychotherapy as made by some of its leading figures may in our view foster fatalism in patients not experiencing major symptom relief by MT.

1. Introduction

Different professions offer help for psychological problems. Conventionally, people suffering from psychiatric disorders such as anxiety and depression consult psychiatrists or psychologists. Alternatively, a growing number of people diagnosed with mental illness go to so-called “healers” and try alternative therapies which are subsumed under the umbrella term “alternative medicine” (AM). A recent German study reported that 37% of psychiatric patients had visited a “healing practitioner” (“Heilpraktiker”) before their hospital stay (Demling, Neubauer, Luderer, & Worthmuller, 2002). For the United States, 21% of those with mental disorders had sought alternative or complementary medicine during the last twelve months (Unützer et al., 2000). Some authors estimate that up to 50% of the general population in English-speaking countries use AM (Silenzio, 2002). Many patients do this in secrecy fearing to be judged as “traitors” by their physicians (White, 2000). The reasons for the increasing acceptance of AM among ill people are complex and beyond the scope of this article. There is some evidence, however, suggesting that many clients prefer AM as conventional medicine does not meet their subjective health care needs (Unützer et al., 2000). For example, 81% of homeopathic patients turned to AM because of dissatisfaction with conventional medicine (Furnham & Smith, 1988). Importantly, a large subgroup of patients with mental illness as well as the general public are very critical of drug administration which is often seen as the standard intervention of conventional medicine (Angermeyer & Matschinger, 1996; Lauber, Nordt, & Rossler, 2005; Moritz, Peters, Karow, Deljkovic, Tonn, & Naber, 2009). Approximately 60% of psychiatric patients endorsed that conventional (chemical) medication should only be used when herbal remedies are not effective (Demling et al., 2002).

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A longstanding schism exists between the academic medical-psychological and the AM field. While a growing number of medical students and doctors show interest in AM (Münstedt, Harren, von Georgi, & Hackethal, 2008) and some supporters of AM in turn recommend the adoption of scientific standards for AM (Walach, 2009), the boundaries are seldom penetrated. AM is often confronted with the criticism that methods are rarely evidence-based beyond observational reports (see for example Vickers & Cassileth, 2008, on "living proof" claims) and uncontrolled trials, are pseudoscientific (Federspil & Vettor, 2000), ignore real scientific evidence (see for example Basford, 2001, on Electric and Magnetic Therapy which these authors view as a typical example of alternative medical practices), exaggerate outcome expectancies (Devilly, 2005), and are mostly performed by people with insufficient (academic) education (Beaven, 1989). Some authors even accuse AM to be an expensive and life-threatening hoax (Beaven, 1989). The psychological-psychiatric help system on the other hand is confronted with the criticism of not being "holistic" (Ventegodt, Andersen, Neikrug, Kandel, & Merrick, 2005; White, 2000), arrogant (Hoey, 1998), and that it neglects and largely ignores alternative interventions (Craig, 2003). The alleged hegemony of the pharmaceutical industry in conventional research is also often criticized (Walach, 2009).

As a rule of thumb, one third of cases with anxiety disorders that complete conventional psychotherapy recover, one third improves and one third does not benefit at all (Eddy, Dutraa, Bradley, & Westen, 2004). Such response rates are pale in comparison to the purported success rates of some alternative therapies which at times promise total symptom eradication within short time (Devilly, 2005). As an example, Gary Craig (2003) claims that his "Emotional Freedom Techniques" (EFT), a variant of "energy psychology", brings benefit to at least 80% of people suffering from all kinds of diseases, whereas conventional psychotherapy is deemed "among the slowest, most ineffective sciences on earth" (p. 15 in the EFT manual). Callahan, the originator of meridian-tapping (MT), even promises success in 97% (see Gaudiano & Herbert, 2000). This may be one of the reasons why MT has received a lot of recognition in the media (e.g., Burkeman, 2007).

In an atmosphere of rivalry and mutual allegations, it does not come to a surprise that AM methods seldom make it into clinical studies (Hoey, 1998). As advocates of AM acknowledge, this is also owing to the fact that very few practitioners with an interest in AM are trained in research (Hoey, 1998).

The first author shares some of the reservations against alternative methods in view of often lacking clinical evidence in parallel to exaggerated success rates, in many cases poor theoretical foundation and over-reliance on observational data that is monocausally interpreted in favor of a respective technique. Nonetheless, it needs to be acknowledged that some evidence-based methods from academic psychology and psychiatry have arisen from serendipity (e.g., the detection of antipsychotic substances like chlorpromazine and clozapine) and some of their explanations have also emerged post-hoc.

The present study is concerned with meridian-tapping (MT) or tapping acupressure. These techniques have been subsumed under the label energy tapping (Gallo & Vincenzi, 2000) or energy psychology (Gallo, 1999). Its perhaps most prominent variant, EFT, has been formulated by Gary Craig, a former engineer. EFT and other meridian-tapping techniques intend to manipulate the body's "energy fields" by tapping on acupuncture points (called meridians) while, for example, a specific traumatic memory (in the case of PTSD), an obsessive thought (in the case of OCD) or another major subjective fear or concern is contemplated. EFT claims to alleviate the core psychological problem lastingly by releasing energy blockages that allegedly cause these negative emotions. According to Craig, the aforementioned success rate for EFT of at least 80% can be considerably raised if certain "impediments to perfection" such as energy toxins (this involves a range of sensitivities to substances including, for example, soap, electricity, sugar and salt) are eliminated (Craig, 2003, pp. 56ff). The spectrum of target disorders is diverse. According to the EFT manual it is applicable to pain relief, anger, addictions, weight loss, anxiety, trauma, depression, fears and phobias, allergies, respiratory problems, blood pressure, relationship issues, "women's issues" and "children's issues".

Critics have refuted the rationale behind MT as pseudoscientific (Gaudiano & Herbert, 2000) and have suggested that any utility of MT stems from well-established cognitive components, such as the placebo effect, distraction from negative thoughts and imaginal exposure, rather than from manipulation of meridians.

The present study was concerned with obsessive-compulsive disorder (OCD), a condition that is characterized by intrusive and bothersome thoughts that its holder tries to reduce by repetitive mental or motor rituals (Abramowitz, 2006; Abramowitz, Taylor, & McKay, 2009). As mentioned above, MT is sometimes attributed to placebo effects. As patients with OCD are not very prone to this bias (Cowen, 1991), possible effects of MT on OCD are unlikely mitigated by this confound. According to the experience of some therapists (Raubart & Seebeck, 2008), MT may exert even larger effect in OCD than in simple phobias.

Before conducting the study, we surveyed the dissemination of MT and the available evidence of MT on anxiety disorders. A search via an online book store revealed more than 40 (self-help) books covering MT for anxiety (October, 2009). In marked contrast and reflecting the schism between the medical and alternative medical fields research engines such as MEDLINE revealed few empirical scientific studies on MT which are summarized in the following.

Waite and Holder (2003) allocated 122 university students with specific fears (e.g., height, animals, public speaking) to four different groups: EFT, placebo tapping, modeling tapping (on a doll instead of one's own body) and a no-treatment group (control). Self-rated fear ratings as assessed with the subjective units of disturbance scale (SUDS) served as outcome measure. All three treatment groups improved significantly, although EFT did not significantly differ from the control group. The authors highlight that MT shares components with more traditional approaches to anxiety treatment that use distraction and desensitization paired with exposure.

Another study conducted by advocates of EFT (Wells, Polglase, Andrews, Carrington, & Baker, 2003) came to a more positive conclusion. A total of 35 subjects with specific phobias of small animals were assigned to EFT or a control intervention (diaphragmatic breathing). Individual treatment lasted for 30 min. Subjects were investigated at three time-points: pre, post and 6–9 months later. Except for the pulse rate and the Behavioral Approach Task (BAT) which measures the level of avoidance of the feared animal, all outcome measures relied on self-report. While the authors report significant pre-post effects for all parameters except pulse rate, these were not retained for the follow-up period except for the BAT. However, the authors claim that follow-up effects are still in the medium-to-strong effect size range ($d > .5$). A closer look at the means, standard deviations and F-values suggests differently. Results are smaller if the difference between both interventions over time is calculated from the effect sizes of the pre and follow-up scores (formula described in Klauer & Phye, 2008, p. 99). While the study generally supports the effectiveness of EFT, interpretative caution is warranted in view of some methodological ambiguities. For example, one third in the experimental and approximately half of the control group were not available for the follow-up endpoint analysis.